PoC accepted 10/15/09 Electronic Test

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN671HOS	A. BUILDING _____ B. WING _____	C 08/13/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW SPRINGS CENTER	690 EDISON WAY RENO, NV 89502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	Initial Comments This Statement of Deficiencies was generated as a result of a State Licensure survey conducted in your facility on 8/10/09 through 8/20/09, in accordance with Nevada Administrative Code, Chapter 449, Hospitals. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.	S 000		
	NAC 449.339 Nutritional Status of Patients 5. A patient must receive a therapeutic diet when it is determined that he has a nutritional problem. This Regulation is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to provide meals that excluded foods that the patient was allergic to for 1 of 21 patients. (Patient #14) Findings include: Patient #14 was admitted to the facility on 7/18/09, with diagnoses including bipolar affective disorder, depression, and post traumatic stress disorder. She was on suicide precautions while at the facility. Record review revealed that Patient #14 had severe food allergies to squash, kiwi and pomegranates. She normally carried an Epi-Pen with her in the event she had an allergic reaction. An order for Epi-Pen was written by the physician on admission and was to be used in the event of anaphylaxis (a severe allergic reaction). Her food allergies were listed on her initial psychiatric	S 194	**NAC 449.339 NUTRITIONAL STATUS OF PATIENTS** Willow Springs Center now ensures provision of meals that identify patients with allergies and excludes foods from their therapeutic diet. **ACTION(S) TAKEN:** 1. The Patient Observation Sheet was reviewed and revised to now include: Allergies and Special Diet. 2. A Unit Meals Form was developed and implemented to ensure that all required elements are communicated, including: a. Unit b. Date c. Meal (Breakfast, Lunch, Dinner) d. Patient's Name e. Allergies f. Special Diet	7/28/09 7/28/09

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (x6) DATE

CMO | 9/10/09

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S 194	Continued From page 1 assessment, initial nursing assessment, medication administration records and on her admission history and physical exam form. Admission orders, written 7/18/09, revealed she was ordered a regular diet. Record review revealed that on 7/23/09, the patient approached the registered nurse and asked for an Epi-Pen. The patient stated she had "just a bite" of a quesadilla containing zucchini. Her eyes were described as slightly swollen and her respiratory rate was rapid with an occasional tight cough. The patient was given Epinephrine and Benadryl to prevent the progression of the allergic reaction. Patient #14's mother was contacted by staff via phone on 7/23/09, and reported that her daughter could have died from eating the zucchini. She stated that the cafeteria worker should have explained to the daughter that zucchini was a squash. On 7/27/09 at 1:20 PM, Patient #14 was given a unit meal obtained from the kitchen. At 1:50 PM, the patient was observed to be coughing and told staff she ate squash because she wanted to die. She was administered Epinephrine. On 8/10/09, a book containing pictures of patients and lists of their food allergies was observed under a table near the serving line in the patient cafeteria. A kitchen worker reported the book was used to identify patients with allergies and to make sure they did not receive foods they were allergic to. Patients were observed being served by kitchen staff. The kitchen staff did not identify patients prior to serving their meal and did not refer to the book to identify patients with allergies.	S 194	3. All nursing and Dietary staff members received education and training on the revised unit meal form. 4. Patients with food allergies are now first in line at the cafeteria to ensure they received the appropriate meal. The back up plan if they are not the first in line will be that the assigned nursing staff member will identify the patient to the dietary staff continues the secondary identification by comparing the patient 's picture for identification and checking the meal form for allergies. 5. As an additional step toward ensuring safety and appropriate diet, the assigned nursing staff member(s) now identifies each patient to the Dietary staff. Dietary staff continues the secondary identification by comparing the patient's picture for identification, and checking meal forms for food allergies. **PERSON(S) RESPONSIBLE:** Director of Nursing Nurse Manager Dietary Supervisor Director of PI/Risk Management. **MONITORING PLAN TO PREVENT RECURRENCE:** A series of audit tools have been developed and implemented to ensure compliance ongoing. Any deficiencies are immediately addressed.	9/8/09 9/8/09 9/8/09

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S 194	Continued From page 2 On 8/12/09, the Director of Nursing, was interviewed. She confirmed that Patient #14 experienced two incidents where she consumed zucchini served by the kitchen. She stated the patient was served zucchini from the tray line the first time she had an allergic reaction. The second exposure to zucchini was the result of a meal obtained from the kitchen by staff and brought to the patient unit. She confirmed that the patient required the administration of Epinephrine for both incidents. She confirmed that the book in the serving area of the kitchen was to be used to identify patients who had food allergies and to prevent patient exposure to the foods they were allergic to. She stated that the book was developed following Patient #14's exposures to zucchini. On 8/12/09, the Food Service Supervisor was interviewed and confirmed the book was made to help staff identify patients with allergies. He reported that the staff may not have used the book during meal service since the they knew the patients who had allergies. Severity 3 Scope 1	S 194	• Special meal process audited three times per week by the dietary supervisor. • Dietary Book is now audited weekly by the Director of PI/RM. • Unit Meal list now audited weekly by the DON and Nurse Manager . Aggregate data from the all audits will be reported to the PI committee monthly for performance improvement activities..	
S 320 SS=G	NAC 449.3628 Protection of Patient 1. A governing body shall develop and carry out policies and procedures that prevent and prohibit: (a) Verbal, sexual, physical and mental abuse of patients This Regulation is not met as evidenced by: Based on record review and interview, the facility failed to ensure that 1 of 70 patients was not sexually abused. (Patient #1)	S 320	**NAC 449.3628 PROTECTION OF PATIENT** Willow Springs Center now ensures that patients are not sexually abused.	

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NAME OF PROVIDER OR SUPPLIER	
WILLOW SPRINGS CENTER	9/21/09

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S 320	Continued From page 3 Findings include: Patient #2 was admitted to the facility on 6/9/09 with diagnoses including depressive psychosis, mood disorder, impulse control disorder, conduct disturbance, development delay, posttraumatic stress disorder, and cannabis dependency. The social history indicated that Patient #1 was sexually abused from age 3-6 and sexually abused other children within the past five years. The patient had aggressive outbursts and was recently described as sexually confused. The 15 year old patient was approximately 5' 7" tall and weighed 155 pounds. There was evidence of a behavioral contract the patient signed on 6/9/09 related to sexual encounters while in the facility. Patient #1 was admitted to the facility on 6/24/09 with diagnoses including mixed anorexia and bulimia, anxiety disorder, and suicidal ideation. He was 15 years old. The patient was 5' 3" tall and weighed 101 pounds. The patient was placed in the room with Patient #2 and remained in the room for three days. After three days staff noticed unusual interactions between the two patients and Patient #1 was moved to a different room. On 8/4/09, Patient #1 approached staff and alleged he had been sexually assaulted by another patient. Patient #1 alleged that Patient #2 had pressured him on 6/24/09 to perform oral sex on Patient #1. Patient #1 admitted that he performed oral sex on and received oral sex from Patient #2 between 10 and 10:15 PM on 6/24/09. Patient #2 admitted the incident did occur, but stated it was consensual. The incident was timed to occur between 15 minute room checks. The facility initiated an investigation and	S 320	**ACTION(S) TAKEN** 1. All clinical staff received remedial training on the policies and procedures related to prevention of verbal, sexual, physical and mental abuse of patients. 2. The procedure for unit/bed assignment of patients upon admission was revised. The Admission department will determine the most effective unit placement based on the following indicators: a.patient age, b.behavioral/clinical issues, c.school grade. The charge nurse with feed back from the MHT staff will make bed assignments, on the unit based using criteria such as: a. age, b. clinical presentation, c. history of boundary violation or sexual acting out, d. identity confusion, e. size or stature. The procedure for patient transfer during treatment was revised. 3. All clinical staff received remedial training on revised policies. 4. Post training, staff were required to demonstrate competency in the following areas: a. Patient Observation b. Room Assignment, c. Notification of therapist d. Motion Sensors	9/21/09 9/21/09 9/21/09 9/21/09

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S 320	Continued From page 4 performed a root cause analysis of the incident in addition to notifying all appropriate persons and agencies, including the police. Interviews with the director of nursing (DON) revealed there was a policy regarding room motion detectors being activated after lights out on the adolescent unit. However, there was no written requirement as to how soon the sensors were activated after lights out. The DON stated the sensors were not activated until patients were settled in their beds. On the night in question, the DON indicated the sensors were not activated until 11:00 PM. A review of the exclusion criteria for facility admissions revealed criteria 5.4 stated generally patients are excluded if they are actively suicidal, actively homicidal, acutely psychotic, or acutely physically or sexually assaultive to self or others. The determination for admission was made by the medical director with input from the DON and the director of social services. The facility failed to ensure that Patient #1 was safe from sexual aggression of Patient #2. Severity 3 Scope 1	S 320	**PERSON(S) RESPONSIBLE:** Director of Nursing Nurse Manager **MONITORING PLAN TO PREVENT RECURRENCE:** The Nurse Manager and/or Supervisor will conduct periodic rounds each shift to ensure that levels of observation and special precautions are implemented as ordered by the physician and in accordance with assessed level of risk and needs. o An audit tool was developed and implemented to monitor revised procedures. DON and/or designee will audit all admissions' for bed assignment and/or transfer of patients during treatment. o Data collected will be analyzed and reported to the PI Committee, MEC and Governing Board. o Staff competency tool was added to the new hire orientation and will be reviewed annually.	9/21/09 9/21/09 9/8/09
S 340 SS=C	NAC 449.363 Personel Policies 5. The hospital shall ensure that the health records of its employees contain documented evidence of surveillance and testing of those employees for tuberculosis in accordance with chapter 441A of NAC. This Regulation is not met as evidenced by: Based on personnel record review the facility failed to provide evidence of pre-employment physical examinations for 9 of 9 employee files	S 340	**NAC 449.363 PERSONAL POLICIES** Willow Springs Center now ensures evidence of pre-employment physical examinations/medical screenings in all employee files.	

FORM APPROVED

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S 340	Continued From page 5 reviewed. Severity 1 Scope 3	S 340	**ACTION(S) TAKEN:** 1. New process for all current employees to have medical screenings was coordinated by the HR Coordinator and DON. 2. Physicals were completed on site by a contracted Physician Assistant for all employees found lacking. 3. All new employees will have a pre-employment screening with Concentra. . **PERSON(S) RESPONSIBLE:** Human Resources Coordinator Director of PI/Risk Management **MONITORING PLAN TO PREVENT RECURRENCE:** 1. The HR Coordinator conducted a 100% review of all employee records to assure evidence of pre-employment health screening. 2. Medical screens will be tracked ongoing through a 100% audit of all new hire files, and sample audits of all files weekly by the HR Coordinator. 3. Audit findings are reported to the PI Committee monthly for tracking, trending, and use for performance improvement activities..	8/29/09 10/9/09 8/31/09